Dr CARLOS A ROJAS DPM
Miami Foot & Ankle | 8740 N Kendall Dr Ste 107, Miami, FL 33176 | (786) 464-9991

New Patient Intake Packet

Please complete before your first visit. Fields may be completed electronically.

Patient Registration

Legal first name _____ **Middle** _____ **Last name** _____

Preferred name _____ **Date of birth (MM/DD/YYYY)** _____ **Age** _____

Sex ☐ Male ☐ Female

Address _____ **Apt/Unit** _____ **City** _____

State _____ **ZIP** _____ **Mobile phone** _____ **Email** _____

Occupation _____ **Employer** _____ **Primary care physician** _____

Emergency Contact

Name _____ **Relationship** _____ **Phone** _____

Preferred Communication

☐ Phone call ☐ Text message ☐ Email ☐ Voicemail

Insurance & Financial Information

Complete the insurance section even if you expect to self-pay.

Primary Insurance

Insurance company _____ **Member ID** _____ **Group #** _____

Subscriber name _____ **Subscriber DOB** _____ **Relationship to patient** _____

Secondary Insurance (if applicable)

Insurance company _____ **Member ID** _____ **Group #** _____

Subscriber name _____ **Subscriber DOB** _____ **Relationship to patient** _____

Responsible Party / Guarantor

☐ Same as patient

Name _____ **Relationship** _____ **Phone** _____

Billing address (if different)

_____

Assignment of Benefits & Financial Responsibility

I authorize release of information reasonably necessary to process claims and request payment of authorized benefits directly to the practice when permitted by my plan. I understand that insurance verification is not a guarantee of payment or coverage. I am financially responsible for copayments, deductibles, coinsurance, non-covered services, services denied as not medically necessary or otherwise excluded, and balances permitted by law and contract. I agree to provide accurate insurance information and promptly notify the practice of changes.

☐ I acknowledge the assignment-of-benefits and financial-responsibility terms above.

Patient/guarantor typed signature _____ **Date** _____

Medical History

Accurate medical history helps us plan safe foot and ankle care.

General Medical Conditions

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Bleeding/clotting disorder
- ☐ Blood clots/DVT/PE
- ☐ Cancer
- ☐ Arthritis
- ☐ Gout
- ☐ Neuropathy/nerve disorder
- ☐ Peripheral vascular disease
- ☐ Autoimmune disease
- ☐ Asthma/COPD
- ☐ Sleep apnea
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Other

Other medical conditions / details

Surgical / Hospitalization History

Prior surgeries and hospitalizations (include approximate dates)

Social History

- ☐ Never smoked
- ☐ Former smoker
- ☐ Current smoker/vape
- ☐ No alcohol
- ☐ Alcohol occasionally
- ☐ Alcohol regularly

Exercise / sports activities

Standing/walking demands at work

Medications, Allergies & Safety

Bring or upload an up-to-date medication list if available.

Medication Allergies

☐ No known drug allergies

Medication / substance allergies and reaction

Current Medications

Medication / dose	How often / reason

Medication / Procedure Safety

☐ I take a blood thinner / anticoagulant

☐ I have an implanted device or pacemaker

☐ I may be pregnant

☐ Not applicable

☐ I have had a prior reaction to local anesthetic

Details for any item checked above

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Foot & Ankle History

Tell us what is bringing you in today.

Main Concern

Primary foot/ankle problem or reason for visit

Which side? (Left / Right / Both)

When did it begin?

Injury date (if applicable)

How did the problem start? Include injury mechanism if applicable.

Symptoms

- ☐ Pain
- ☐ Swelling
- ☐ Bruising
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Instability/giving way
- ☐ Limited motion
- ☐ Skin/nail problem
- ☐ Difficulty walking
- ☐ Other

Pain 0-10

What makes it worse?

What makes it better?

Prior treatment, imaging, injections, therapy, orthotics, surgery, or medications for this problem

Your main goal for this visit

Consent to Care & Communication

General consent for evaluation and routine treatment; procedure-specific consent may be obtained separately.

General Consent for Evaluation and Treatment

I voluntarily consent to evaluation and medically appropriate treatment by Dr CARLOS A ROJAS DPM and authorized clinical staff. I understand that evaluation may include history, physical examination, review of records, diagnostic testing or imaging orders, and routine office-based care as clinically appropriate. No guarantee has been made regarding diagnosis, treatment outcome, or recovery. I understand that specific procedures, surgery, injections, regenerative therapies, or other treatments may require separate informed consent.

☐ I consent to evaluation and routine treatment.

Electronic & Telephone Communications

The practice may use phone, voicemail, text message, or email for scheduling, reminders, administrative questions, and other communications I authorize. I understand that ordinary email and text messaging may carry privacy risks. I may change my communication preferences by notifying the practice.

☐ I authorize appointment reminders by text.

☐ I authorize appointment reminders by email.

☐ I authorize voicemail messages that identify the practice and appointment date/time.

Preferred mobile number _____

Preferred email _____

People We May Speak With

List people you authorize us to speak with about appointments, billing, and/or your care. This does not replace a HIPAA authorization when one is legally required for a specific disclosure.

Name	Relationship	Phone

Name	Relationship	Phone

Patient / representative typed signature _____ **Date** _____

Notice of Privacy Practices (HIPAA)

Effective date: August 11, 2026 • Please review carefully.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and the privacy responsibilities of this practice.

Your Rights

- Get an electronic or paper copy of your medical record and other health information we maintain about you.
- Ask us to correct health information you believe is incorrect or incomplete.
- Request confidential communications, such as contacting you at a specific phone number or address.
- Ask us to limit certain uses or disclosures. We are not always required to agree, except as required by law.
- If you pay for a service in full out of pocket, ask us not to disclose that information to your health plan for payment or health care operations unless disclosure is required by law.
- Request an accounting of certain disclosures of your health information.
- Get a paper copy of this Notice at any time.
- Choose a personal representative who is legally authorized to act for you.
- File a privacy complaint without retaliation.

Your Choices

- You may tell us whether and how to share relevant information with family, friends, or others involved in your care or payment for your care.
- You may tell us your preferences for disaster-relief communications and other permitted disclosures.
- We will obtain written permission when HIPAA requires authorization, including most uses or disclosures for marketing, sale of protected health information, and most psychotherapy-note disclosures.

Substance Use Disorder Records

To the extent this practice receives records protected by 42 CFR Part 2 concerning substance use disorder treatment, those records receive additional protections. Such records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a qualifying court order and subpoena, as applicable.

Notice of Privacy Practices (continued)

How we may use and disclose your health information.

Common Uses and Disclosures

Treatment	We may use and disclose your health information to provide, coordinate, or manage your care and to communicate with other health professionals involved in your treatment.
Payment	We may use and disclose information to bill and obtain payment from health plans or other responsible parties.
Health Care Operations	We may use and disclose information to run the practice, improve quality, train staff, conduct audits, and manage services.
Public Health and Safety	We may disclose information for legally permitted public-health activities, product recalls, adverse-event reporting, suspected abuse or neglect, or to prevent a serious and imminent threat.
Health Oversight and Law	We may disclose information when required or permitted by law, including to health oversight agencies and the U.S. Department of Health and Human Services for compliance activities.
Workers' Compensation / Government Functions	We may disclose information as permitted for workers' compensation, law-enforcement purposes, and certain government functions.
Legal Proceedings	We may disclose information in response to a court or administrative order or other lawful process, subject to applicable federal and Florida requirements.
Coroners / Medical Examiners / Funeral Directors / Organ Donation	We may make disclosures as permitted by law for these purposes.
Research	We may use or disclose information for research only when permitted by law and applicable authorization or waiver requirements.

Florida Confidentiality

Florida law generally protects the confidentiality of patient records and restricts disclosure to people outside your care except with written authorization or as otherwise permitted or required by law. The practice maintains policies and procedures intended to protect the confidentiality and security of medical records and maintains disclosure documentation as required.

Notice of Privacy Practices (continued)

Our responsibilities, changes to this notice, and complaints.

Our Responsibilities

- We are required by law to maintain the privacy and security of protected health information.
- We will notify affected individuals as required if a breach occurs that may compromise the privacy or security of protected health information.
- We must follow the duties and privacy practices described in the Notice currently in effect.
- We will not use or disclose your information other than as described in this Notice unless you authorize us in writing or another law permits or requires the use or disclosure.
- If you give written authorization, you may generally revoke it in writing, except to the extent we have already relied on it.

Changes to This Notice

We may change the terms of this Notice and make the revised Notice effective for all protected health information we maintain. The current Notice will be available upon request, at the office, and on the practice website.

Questions or Complaints

Privacy Contact: Dr CARLOS A ROJAS DPM / Privacy Officer
8740 N Kendall Dr Ste 107, Miami, FL 33176 • (786) 464-9991
You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. The practice will not retaliate against you for filing a complaint.

Practice note: keep this Notice current, post it prominently at the office and on the practice website, and revise it when material privacy practices change.

Acknowledgment of Notice of Privacy Practices

Acknowledgment of receipt - not an authorization for special uses or disclosures.

Acknowledgment

I acknowledge that I received or was offered the Notice of Privacy Practices for Dr CARLOS A ROJAS DPM. My signature acknowledges receipt of the Notice; it does not authorize any special use or disclosure of my health information.

☐ I received / was offered a copy of the Notice of Privacy Practices.

Patient / representative typed signature _____ **Date** _____

If representative, relationship / authority

_____

Office Use Only - if acknowledgment not obtained

☐ Patient declined to sign ☐ Emergency treatment ☐ Other reason

Good-faith effort / reason acknowledgment was not obtained

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Authorization to Release / Obtain Health Information

Optional form. Use when a specific HIPAA authorization is needed.

Patient & Records

Patient name | **Date of birth** | **Phone**

I authorize: **Person / organization authorized to disclose information**

Address / fax / secure contact

To disclose to: **Recipient / organization**

Address / fax / secure contact

Information Authorized

- ☐ Complete medical record
- ☐ Office notes
- ☐ Imaging / reports
- ☐ Billing / insurance records
- ☐ Lab / pathology
- ☐ Other

Other / date range / specific records

Purpose (or 'at my request')

Expiration date/event

Delivery method (secure fax/portal/mail/etc.)

I understand that I may revoke this authorization in writing except to the extent action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization except where permitted by law. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA, although other laws may apply.

Patient / legal representative typed signature

Date

If representative, describe authority

Florida Patient Rights & Responsibilities - Practice Summary

For patient convenience; this summary does not replace applicable statutes or facility notices.

Patient Rights

- Receive considerate and respectful care and information about the identity and qualifications of health care providers involved in your care.
- Receive information about diagnosis, proposed treatment, alternatives, risks, and expected outcomes as appropriate to informed decision-making.
- Participate in decisions about your care and refuse treatment to the extent permitted by law, understanding potential consequences.
- Have medical records and communications handled confidentially as required by federal and Florida law.
- Request access to or copies of medical records as provided by applicable law.
- Receive information about charges and available payment information upon request, subject to applicable law and insurance arrangements.
- Raise concerns or complaints without retaliation.

Patient Responsibilities

- Provide accurate and complete information about symptoms, medical history, medications, allergies, insurance, and changes in health.
- Ask questions when you do not understand your condition, treatment plan, instructions, or financial responsibilities.
- Follow agreed treatment plans and let the practice know when you cannot follow them.
- Keep appointments or provide reasonable notice when you must cancel or reschedule.
- Treat staff and other patients respectfully and follow reasonable practice policies.
- Meet financial obligations for care as permitted by law and applicable insurance agreements.

Florida law contains additional rights and responsibilities that may apply depending on the setting and services provided. Patients may request additional information from the practice.

Patient Attestation & Signature

Review the packet before signing.

Attestation

I certify that the information I provided in this packet is true and complete to the best of my knowledge. I understand that I should update the practice when my medications, allergies, insurance, contact information, or health history changes.

☐ I have reviewed the information I entered in this packet.

☐ I understand that procedure-specific informed consent may be required separately.

Patient / legal representative typed signature _____ **Date** _____

Printed name _____ **Relationship if representative** _____

Website / Electronic Submission Safety

If this packet is embedded on the practice website, patients may fill and download it. Completed forms contain protected health information. Do not instruct patients to return completed forms through ordinary email or an unsecured website upload. Use a HIPAA-compliant patient portal, secure encrypted upload, secure fax, or in-office delivery.

Dr. Carlos A. Rojas, DPM
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Professional Liability Insurance Notice

Notice to Patient

Dr. Carlos A. Rojas, DPM does not carry professional liability (medical malpractice) insurance.

Patient Acknowledgment

I acknowledge that I have been informed that Dr. Carlos A. Rojas, DPM does not carry professional liability (medical malpractice) insurance.

Patient name _____ Date of birth _____

Patient/representative signature _____ Date _____

Representative name / relationship (if applicable) _____

Acknowledgment of notice only; no waiver of patient rights is stated or implied.